NAMIBIA AND HIV/AIDS

Key Talking Points

Namibia is ranked as one of the four countries in the world most affected by HIV/AIDS, and prevalence rates continue to rise to alarming levels:

- More than 20 percent of adults (15 to 49 years old) are HIV-positive and likely to die within the next seven years.
- An estimated 150,000 to 180,000 Namibians are living with HIV. With current trends, this figure is expected to rise to 400,000 by the year 2000.
- Over 12,700 new cases of HIV infection were reported in 1998, bringing the total number to 53,000.

AIDS Deaths From 1990 to 2010, AIDS will increase the crude death rate in Namibia by more than 233 percent. Although vastly under-reported, the official number of AIDS deaths increased by over 40 percent in 1998. In 1998, AIDS continued as the number one killer of Namibians, causing more deaths (23 percent) than tuberculosis (12 percent) and malaria (5 percent) combined. Average life expectancy in the year 2000 will be 52 years; by 2010 it will be 38 years.

AIDS Costs If HIV/AIDS continues to spread at its current rate, direct costs to the health system will increase from the current 2.9 percent to 17.2 percent by 2001. A calculation of expected direct and indirect costs over the next five years reveals that Namibia can expect to lose as much as N$8 billion to the epidemic by 2003, a real challenge for a newly independent country with a fragile economy and scarce human resources.

Women and HIV/AIDS The number of women living with HIV/AIDS was estimated at 75,000 in 1997. Sentinel surveillance data among pregnant women illustrate a rising HIV prevalence rate, with three sites reporting 29 percent or more.

Children, Youth and HIV/AIDS By the period 2000 to 2005, infant mortality is expected to be at least 40 percent higher because of AIDS; by 2010 the rate will be 63 percent higher. In 1998 the child mortality rate (under age 5) was 125.5 with AIDS as a factor and 62 without—a 50 percent increase.

National Response Recent proposals have been advanced to make AIDS a "notifiable" disease. The government believes this would destigmatize AIDS and thus more effectively combat the epidemic. Doctors would be required to notify those closest to the patient about his or her status, and relatives and partners will be given counseling after notification. It will be essential for the new national coordinating program to provide/mobilize the resources and technical support required to carry out the new national program.

USAID is the major donor supporting lower-primary education reform, providing assistance to the Parliament, and generating income for historically disadvantaged Namibians through community-based natural resources management. In HIV/AIDS prevention, USAID has supported efforts in counseling and home-based-care training of trainers. Namibia is scheduled to graduate from U.S. assistance in 2005.

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Country Profile

Namibia gained its independence from South Africa in 1990 after more than 20 years of war. The country's per capita income of $1,984 (1997) is one of the highest in sub-Saharan Africa, but this figure masks a highly inequitable income distribution: The richest 10 percent of Namibian society receive 65 percent of the national income. About half the population of 1.6 million survive on approximately 10 percent of the average per capita income, while 5 percent enjoy incomes that are five times this average.

Approximately 60 percent of the majority black population live in rural areas on communal lands, surviving on yearly annual incomes of $100 to $200. This economic disparity is a legacy of the pre-independence system of apartheid. Unequal access to health care services (87 percent urban, 42 percent rural), safe water (87 percent urban, 42 percent rural), and sanitation (77 percent urban, 12 percent rural) are issues related directly to institutionalized economic inequities and a history of minority-dominated government. According to UNAIDS, the gross domestic product (GDP) growth rate declined steadily from 6.7 percent in 1994 to 1.8 percent in 1997.

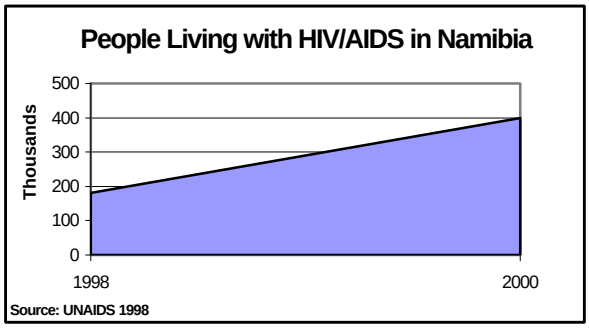
Namibia continues to face serious social and economic challenges. A 1998 UNDP report indicates that, in terms of social indicators, Namibia is in the relatively-least-developed category. At least one-third of the population suffer from poverty, which is reflected in widespread malnutrition (15 percent of children under age 5 are underweight), unemployment and underemployment (40 percent), and a high overall HIV-prevalence rate among adults (20 percent). There is a high fertility rate of 4.7 (1996).

According to Namibia's Human Development Report for 1997, if HIV/AIDS continues to spread at its current rate, direct costs to the health system will increase from the current 2.9 percent to 17.2 percent by 2001. A calculation of expected direct and indirect costs over the next five years reveals that Namibia can expect to lose as much as N$8 billion to the epidemic by 2003, a real challenge for a newly independent country with a fragile economy and scarce human resources.

HIV/AIDS in Namibia

The first four AIDS cases were reported in Namibia in 1986. Over the following decade, the number increased more than 650 percent. The HIV/AIDS prevalence rate continues to rise to alarming levels, with Namibia ranking as one of the four most-affected countries in the world, along with Zimbabwe, Botswana, and Swaziland.

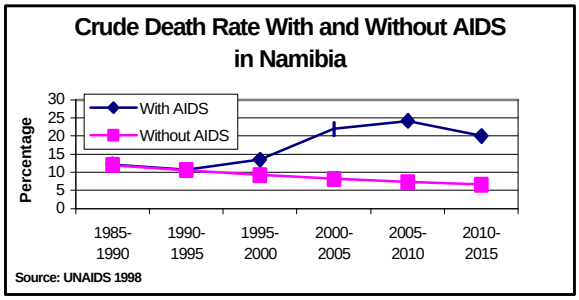
- More than 20 percent of adults (15 to 49 years old) are HIV-positive and likely to die within the next seven years.
- As of May 1999, an estimated 150,000 to 180,000 Namibians are living with HIV (UNAIDS and Ministry of Health and Social Services estimates). With current trends, this figure is expected to rise to 400,000 by the year 2000.
- According to the Ministry of Health and Social Services, more than 12,700 new cases of AIDS were reported in 1998, bringing the total number to over 53,000.



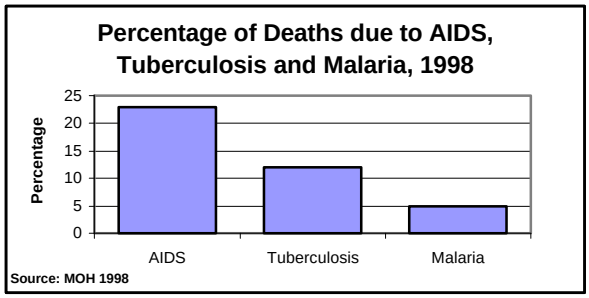
- A 1998 Ministry of Health and Social Services survey of pregnant women at antenatal clinics in five sites indicated an HIV prevalence rate in excess of 20 percent; rates at three sites were closer to 30 percent.

From 1990 to 2010, AIDS will increase the crude death rate in Namibia by more than 233 percent.

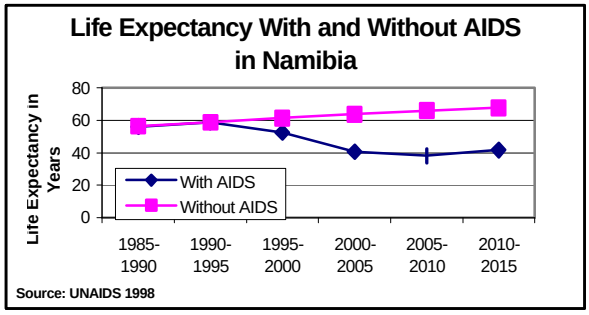
- Though vastly under-reported, the official number of AIDS deaths increased by over 40 percent in 1998. By 2010 there will be an estimated 192 percent more deaths with AIDS as a factor.



- In 1998 AIDS continued as the number one killer of Namibians, causing more deaths (23 percent) than tuberculosis (12 percent) and malaria (5 percent) combined.



- UNAIDS estimates that 6,400 people died of AIDS-related diseases in 1997.
- According to UNAIDS statistics, life expectancy in the year 2000 will be reduced by 15 percent and, by 2010, average life expectancy will be 38 years, a decrease of 42 percent.



Women and HIV/AIDS

The number of women living with HIV/AIDS (estimated at 75,000 in 1997) is growing. Women's low social and economic status, combined with greater biological susceptibility to HIV, put them at increased risk of infection. Economic conditions in Namibia, which make it difficult for women to access health and social services, compound their vulnerability. Sentinel surveillance data among pregnant women at antenatal clinics illustrate this rising HIV prevalence rate:

Site	1994	1996	1997	1998
Oshakati	14%	22%	--	34%
Walvis Bay	--	--	--	29%
Katima Mulilo	24.5%	24.2%	25.7%	29%
Windhoek	4%	7%	16%	23%
Onandjokwe	--	8%	17%	21%
Engela	--	7%	18%	17%
Otjiwarango	2	9	--	16%
Andara	2.1%	10.5%	--	17.3%
Swakopmund	3%	7%	17%	15%
Rundu	8.4%	8.4%	18%	14%
Nankudu	--	--	--	13%
Nyangana	6.%	5.3%	6.8%	10%

Gobabis	1%	--	--	9%
Keetmanshoop	3%	8%	--	7%
Opuwo	3%	1%	--	6%

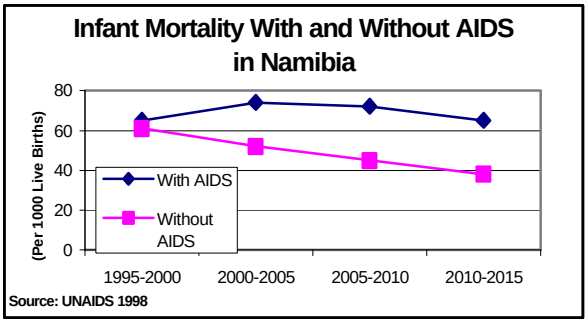
HIV Infection Rates Among Pregnant Women Attending ANC Clinics
(Source: NACP/MOHSS 1998)

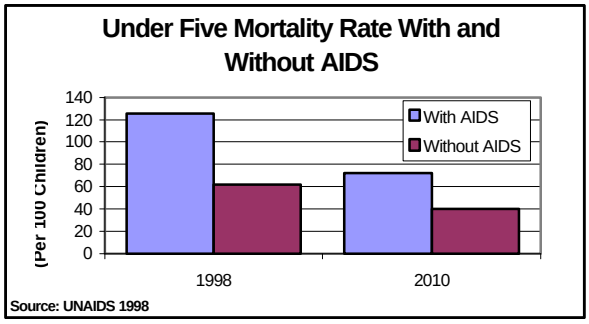
Children, Youth and HIV/AIDS

Forty-two percent of the Namibian population is under age 15. UNAIDS estimates that 5,000 Namibian children were living with HIV/AIDS in 1997. The HIV epidemic has a disproportionate impact on children, causing high morbidity and mortality rates among infected children and orphaning many others. Approximately 30 to 40 percent of infants born to HIV-positive mothers will also become infected with HIV.

- By the period 2000 to 2005, infant mortality is expected to be at least 40 percent higher due to AIDS. By 2010 the rate will be 63 percent higher.
- According to Bureau of Census data, in 1998 the child (under age 5) mortality rate was 125.5 with AIDS as a factor, compared to 62 without—a 50 percent increase. By 2010 the rate will be 72 with AIDS as a factor, compared to 40 without.

Data from the Population Policy Data Bank (under the UN Secretariat) reveals that teenage pregnancy is a matter for serious concern. One family health survey revealed 35 percent of adolescents reported unwanted pregnancies, an indication of unprotected sexual behavior.





Socioeconomic Effects of AIDS

About 90 percent of reported AIDS cases are 20 to 49 years old. Since this age group constitutes the most economically productive segment of the population, an important economic burden is created. Productivity falls and business costs rise—even in low-wage, labor-intensive industries—as a result of absenteeism, the loss of employees to illness and death, and the need to train new employees. The diminished labor pool affects economic prosperity, foreign investment, and sustainable development.

There are also many private costs associated with AIDS, including expenditures for medical care, drugs, funeral expenses, etc. The death of a family member leads to a reduction in savings and investment, and increased depression among remaining family members. Women are most affected by these costs and experience a reduced ability to provide for the family when they spend a significant portion of their time caring for sick family members. AIDS adversely affects children, who lose proper care and supervision when parents die. Some children will lose their father or

Namdeb, a major mining company, has experienced major declines in STI rates and new HIV infections, due to its peer education program, dissemination of HIV/AIDS information and condoms to its workforce and the surrounding community, and its practice of nondiscrimination against PLWHA. The Chamber of Mines facilitated the replication of this program and, as of 1998, most major mines had become involved.

mother to AIDS, but many more will lose both parents, causing a tremendous strain on social systems. At the family level there will be increased pressure and stress on the extended family to care for these orphans; grandparents will be left to care for young children and 10- to 12-year-olds become heads of households.

(For country-specific information on the impact of HIV/AIDS refer to the *socioeconomic analysis* presented by the Policy Project.)

Interventions

National Response

The National AIDS Control Program (NACP) was established in 1990 under the Ministry of Health and Social Services, with support from WHO and several bilateral donors. The first Medium Term Plan (MTP1), for the period 1992 to 1997, focused on prevention, condom promotion, HIV/AIDS/STI case management, and epidemiological surveillance. Over time, other sectors have increased their involvement, largely in the area of prevention. Outside the Ministry of Health and Social Services, the most active ministries are Basic Education and Youth and Sport, which implement a national life-skills curriculum for adolescents in secondary schools through the Youth Health Development Program (YHDP). YHDP is financed by the Swedish government, Irish AID, and the German Committee of UNICEF. Youth mobilized by the YHDP are becoming a major resource for youth-led action at national and regional levels.

The new (1999) National AIDS Coordination Program (NACOP) and national strategic plan of action (MTP2) are key to the expansion of the national response. A widely participatory process at both sectoral and regional levels has contributed to a greater understanding among policy makers of the broad impact of the epidemic, including such issues as social support, legal reform, home-based care and economic impact. NACOP remains under the leadership of the Ministry of Health and Social Services. The National AIDS Committee, co-chaired by the Minister of Health and Social Services and the Minister of Local Government and Housing, is comprised of ministers from all sectors and is the key HIV/AIDS policy making body. The National Multisectoral Coordination Committee (NAMACOC) is chaired by the Permanent Secretary of the Ministry of Health and Social Services and includes all the regional governors, permanent secretaries from all key ministries, nongovernmental organizations (NGOs), and private sector representation. The UN system is also represented on NAMACOC. The National AIDS Executive Committee, chaired by the Undersecretary of the Ministry of Health and Social Services, is the key implementing body. Over the next five years, the bulk of resources will be allocated for information dissemination and condom promotion, with the addition of access to services for people infected and affected by HIV/AIDS. The estimated five-year cost is US$11,680,000, mainly for health sector activities. Other sectors are currently developing detailed plans and budgets.

NAMACOC members include all 13 regional governors, who are expected to produce regional strategic plans of action. The capacity to design and implement programs varies among the regions, and technical, financial, and human resources may be needed.

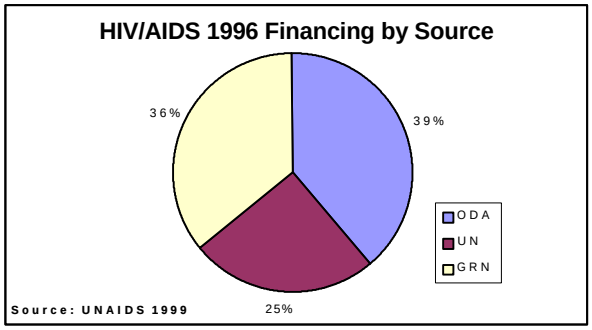
Recent proposals have been advanced to make AIDS a "notifiable" disease. The government believes this would destigmatize AIDS and thus more effectively combat the epidemic. Doctors would be required to notify those closest to the patient about his or her status, and relatives and partners would be given counseling after notification. These proposals resulted from a meeting of Ministers of Health from the Southern African Development Community, and are intended as a move towards addressing the disease as a public health epidemic.

The "Youth Africa" social marketing AIDS talk-show addresses topics such as HIV/AIDS, sexually transmitted infections (STIs), sex, and unintended pregnancy. The program targets low-income urban youth (15 to 25 years old) in Windhoek. The Namibia affiliate of Population Services International receives in-kind support

from the government and collaborates with Namibia's radio services to produce programming in three languages.

In May 1999 the Ministry of Health and Social Services hesitated to join a five-year, US$100 million AIDS prevention program, sponsored by an international pharmaceutical company, "Secure the Future: Care and Support for Women and Children with AIDS," targeting Namibia and four other Southern African countries. Efforts are underway to provide more information about the initiative to policy makers and ensure that any funds that might become available are channeled to nationally-defined priorities.

In 1996, approximately US$2 million supported HIV/AIDS activities, with financing from GRN, the UN, and other donor agencies (ODA).



Donors

In FY 1997 bilateral donors provided the bulk (nearly 80 percent) of overall external aid to Namibia, followed by multilateral organizations (18 percent) and international NGOs (4 percent). Until there are sufficient numbers of skilled Namibian personnel to manage large, complex programs, there will be a continued need for donor support in capacity building and assistance in program management, monitoring, and evaluation. According to a UNAIDS/Harvard study, bilateral organizations contributed the following amounts towards HIV/AIDS in 1996-97 and 1998-99:

Organization	Amount US$ 1996-97	Amount US$ 1998-99
Germany *(reproductive health 1999-2002)*	800,000	1,590,000
USAID	600,000	n/a
Norway	326,000	n/a
Spanish Cooperation	n/a	184,000
Spain	69,000	n/a
Sweden *(pending)*	n/a	450,000
Total	**1,795,000**	**2,224,000**

Bilateral organizations' contributions 1996-1999

USAID has no HIV/AIDS-specific funding as of 1998. However, several HIV/AIDS activities are carried out through other development activities. The priority goal of the mission performance plan is to "promote sustainable and equitable economic growth in Namibia." Three of the four strategic objectives and the bulk of USAID/Namibia funding support this goal. The FY 1999 program focuses on strengthening Namibia's new democracy through the social, economic, and political empowerment of Namibians disadvantaged by apartheid. USAID is the major donor supporting lower-primary education reform, providing assistance to Parliament, and generating income for historically disadvantaged Namibians through community-based natural resources management. In HIV/AIDS prevention, USAID has supported efforts in counseling and home-based-care training of trainers. Namibia is scheduled to graduate from U.S. assistance in 2005.

UNAIDS has a coordinating Theme Group based in Namibia, which includes representatives from

UNICEF, UNDP, UNESCO, UNFPA, WHO, and the FAO, and is chaired by WHO.

The UN has provided extensive support to the government in the national strategic planning process, and continues its advocacy role in securing political and financial commitment from government. The Theme Group will be represented at the policy and program levels as a member of the NAMACOC and the National AIDS Executive Committee, its operational arm. There are three Technical Working Groups: Communications/Youth (chaired by UNICEF), Health (chaired by WHO), and Mitigation/Social Services (chaired by UNDP). UNAIDS has contributed US$628,894 from 1996 to 1999.

WHO pledged N$1.8 million to support the newly formed NACOP, and provided technical assistance in organizing resource mobilization by preparing information for major donors and partners, including national ones, at a June 1999 meeting. WHO recently launched an emergency plan on AIDS, focusing on assisting Regional Health Management Teams in the five most-affected areas.

UNICEF helps fund the Youth Health Development Program (US$170,000, 1996-1999).

The European Union (EU) supports STI case management and epidemiological surveillance.

The German Government, Federal Ministry for Economic Cooperation and Development (GTZ) supported family planning/HIV prevention in 1997 with DM 5.5 million, and continues efforts in reproductive health and condom social marketing.

The French government is active in behavioral research, management support, and information, education, and communication (IEC).

The Swedish International Development Agency (SIDA) supports the "Life Skills" aspect of the Youth Health Development Program.

Norway (NORAD) provides support to NGOs.

Spanish Cooperation, in collaboration with UNAIDS and the Ministry of Health and Social Services, supports HIV/AIDS counselors, the training of new counselors at the regional level, and a bimonthly newsletter.

Private Voluntary Organizations (PVOs) and Nongovernmental Organizations (NGOs)

A number of PVOs implement activities funded by multilateral and bilateral donors. *See attached preliminary chart for PVO target areas for HIV/AIDS activities. This list is evolving and changes periodically.*

A variety of NGOs are pursuing HIV/AIDS activities in Namibia, including several AIDS service organizations, trade unions, community theater groups, and broader NGOs such as the Red Cross, the YMCA/YWCA, World Education, and Oxfam. A major initiative to provide parish-level capacity for home-based care was recently launched by the Namibian Catholic Bishops Conference. The Council of Churches of Namibia is preparing a similar initiative.

The Namibian Network of AIDS Service Organizations (NANOSO) is a coalition of NGOs working in HIV/AIDS.

Challenges

Major constraints to HIV/AIDS control in Namibia include the following:

- The stigma surrounding HIV/AIDS precludes voluntary counseling and testing and, consequently, the environment for high-risk behavior change.
- There is a critical shortage of skilled human resources.
- Ongoing coordination at both the policy and operational levels will be challenging.
- Although there is considerable donor interest in supporting NGO activities, the NGO community suffers from rapid staff turnover and limited capacity to organize activities and account for funds.

The following gaps in programming must be filled in order to mount an effective response to HIV/AIDS in Namibia:

- Management capacity in the NACOP needs to be developed.
- Voluntary counseling and testing sites must be established.
- Surveillance and research must be improved.
- NGOs need management and organization skills to improve service delivery and earn credible participation in policy dialogue.

The Future

Political commitment, completion of the new national strategic plan, and the launching of new government structures have set the stage for progress, but progress will only be achieved if the human and financial means are also available. It will be essential for the new national coordinating program to provide/mobilize the resources and technical support required to carry out the new national program. This will be an ongoing process, involving the private sector as well as the government and donor agencies. A valuable partner in this endeavor would be the church community, which is very influential in most sectors of society.

Important Links

1. The National AIDS Coordination Program (NACOP): Private Bag 13198, Windhoek. Tel: (264-61) 225-015; Fax: (264-61) 224-115; Email: nacp@iafrica.com.na
2. UNAIDS Country Program Adviser: Mary Guinn Delaney, c/o UNDP, Private Bag 13329, Windhoek. Tel: (264-61) 229-220 or 200-1190 (direct); Tel mobile: (264-81) 124-6543; Fax: (264-61) 229-084; E-mail: maryguinn@un.na
3. Namibian Network of AIDS Service Organizations: P. O. Box 233, 281 Windhoek. Fax:(264-46) 126-1122

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June 1999

Namibia

Organization	Intervention															
	Advoc.	BCI	Care/S	Training	Cond.	SM	Eval.	HR	IEC	MTCT	Research	Policy	STD	VCT	Orphan	TB	Other
Cooperating Agencies																	
PSI					X									X			
Peace Corps									X								
PVOs/NGOs																	
Civil/Military Alliance to Combat HIV/AIDS	X			X				X				X					
World Weducation				X					X								
Oxfam									X								

KEY:

Advoc.	Advocacy	**MTCT**	Mother to Child Transmission activities
BCI	Behavior Change Intervention	**Research**	HIV/AIDS research activities
Care/S	Care & Support Activities	**Policy**	Policy monitoring or development
Training	HIV/AIDS training programs	**STD**	STD services or drug distribution
Cond.	Condom Distribution	**VCT**	Voluntary counseling and testing
SM	Social Marketing	**Orphan**	AIDS orphan activities
Eval.	Evaluation of several projects	**TB**	TB control
HR	Human Rights activities	**Other**	(I.e. blood supply, etc.).
IEC	Information, education, communication activities		